

# Centring Community Services Around Early Childhood Care and Development: Promising Practices in Indigenous Communities in Canada

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## Abstract

The conceptualization and enactment of culturally congruent plans for innovating new programs in three groups of Indigenous communities in Canada are described. These case studies illustrate the processes and outcomes of moving beyond the rhetoric of ‘holistic’ and ‘integrated’ services to engage incrementally in steps that hold promise for a seamless joining together of services across sectors, across professional disciplines, and even across cultures. These initiatives attest to the benefits of long-term, comprehensive community consultation and planning, good governance within community, and steadfast commitment to the well-being of the youngest generation as a priority for community development.

There are between 250 and 350 million Indigenous peoples around the world, comprising an estimated 4 to 6% of the world’s population (United Nations Educational Scientific and Cultural Organization [UNESCO], 2006). In Canada, among a total of 31,240,030 Canadians in 2006, 1,172,790 (3.8 %) identified as a member of one of the Indigenous populations recognized by the Constitution Act of 1982: North American Indian (commonly known as First Nations), Métis, and Inuit. Young Indigenous children make up an increasing proportion of all children in Canada, primarily as a result of a birth rate that is nearly twice that of the non-Indigenous population (Statistics Canada, 2006).<sup>1</sup> Like

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<sup>1</sup> First Nations, Inuit and Métis peoples are the original inhabitants of the land now called Canada. Taken together, these populations were referred to by the colonial government of Canada as ‘Aboriginal’ peoples. Many services, programs, policies, and laws specifically designed for these populations are referred to as ‘Aboriginal’ (e.g., ‘Aboriginal Head Start’ and ‘Aboriginal Healing Foundation’). A growing number of First Nations, Inuit and Métis people prefer to be referred to as ‘Indigenous’ peoples, avoiding a colonial name and linking them to other Indigenous populations around the globe. Many are also requesting to be

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many Indigenous peoples worldwide, First Nations, Métis and Inuit peoples experienced centuries of colonial government interventions that depleted their community, family and personal resources. They are now struggling to regain their strengths as families and communities, to restore cultural pride, and to equitable opportunities for optimal health, development and education.

National organizations representing First Nations, Métis and Inuit peoples have all identified early childhood care and development (ECCD) training and services as priorities within a holistic vision of social development, population health, and economic advancement (see Canada Council on Learning, 2007). ECCD is seen as essential for protecting and enhancing the physical health, psycho-social well-being, and positive cultural identity of Indigenous children and their families. In British Columbia, a 1992 Aboriginal Committee Report on Family and Children's Services Legislation stated that: "Our main goals are to preserve and strengthen our culture; to support and maintain the extended family system; to promote the healthy growth and development of our children and to develop community-based programs conducive to the realization of these goals" (Aboriginal Committee, Community Panel, 1992, p. 9). The need to strengthen community capacity for ECCD is particularly urgent for First Nations living on reserves, where access to children's programs and family supports is limited by geographic distances, social and cultural barriers, and government regulations regarding children's eligibility for programs and services (Ball, 2008).<sup>2</sup>

This article describes promising practices in three groups of First Nations communities that are building community-based infrastructure to support the holistic development of young children and their families. A documentation research project conducted through partnerships between the participating communities and the author showed the successes that are being realized in these visionary and resourceful First Nations communities, from unprecedented high rates of training program completion and transition to career-relevant work. These communities are creating programs that are

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called by their specific ethnic group (First Nations, Inuit or Métis) or by the name of their specific clans or community (e.g., Lil'wat), and are calling for population level data to be presented in a disaggregated rather than an aggregated way. In this article, the term First Nations is frequently used, because all of the communities that participated in the research were First Nations. The term Aboriginal is used when the formal name of a program includes this term, or when aggregated census data are being cited.

Between 1996 and 2006, the Aboriginal population in Canada grew by 45%, nearly six times faster than the 8% increase of the non-Aboriginal population (Statistics Canada, 2006).]

<sup>2</sup> There are currently 605 registered First Nations, representing approximately 500,000 status (registered) First Nations people living on reserve lands. 'Reserves' (formerly known in Canada as reservations) are lands that have been set aside by the federal government specifically for First Nations peoples. Historically, the allocation of reserve lands was used as a form of apartheid, to segregate First Nations who refused to relinquish their status as 'Registered Indians.' Movement of First Nations on and off reserves was restricted, and activities on reserves were limited. Currently, many of these restrictions have been lifted. However, the extent of control of First Nations to their reserve lands, and the boundaries of territories that should belong to particular First Nations, are highly contested issues in Canada. For the purposes of this article, it is important to note that First Nations children and families living on reserves are provided with programs and services via the federal government, whereas these are provided First Nations and all other Canadians living off reserves via the provincial governments. Generally it is understood that First Nations living on reserve receive a more limited range of services, including for example access to ancillary clinical services and family support programs, and they have more difficulty accessing the diagnostic and early intervention services.

Groups of First Nations are often organized for administrative purposes into Tribal Councils or Tribal Associations.

relevant and appropriately utilized by community members and that are helping to revitalize Indigenous knowledge and languages. All of the communities have committed to some degree of integrated service delivery consistent with their understanding of needing to support the “whole child” in the context of family-centred and community-centred practice.

### **Predominant Patchwork Approach to Services**

Most communities in Canada today maintain an individual-centred and non-integrated approach to family and children's services. In this fragmented model, people receiving services are conceived as individual cases with an array of separate needs, subject to servicing by an array of separate professional service providers (see Figure 1). The fragmentation of training and services into increasingly differentiated domains of specialization corresponds to dominant cultural constructions of the child in psychology and education as a collection of “domains” of development, each with distinct proclivities, potential, and needs for different kinds of support. In First Nations communities, practitioners specializing in different domains of child and family health and development are usually located outside of the community, not just administratively, culturally, and socially but, in the case of rural and remote communities, geographically as well.

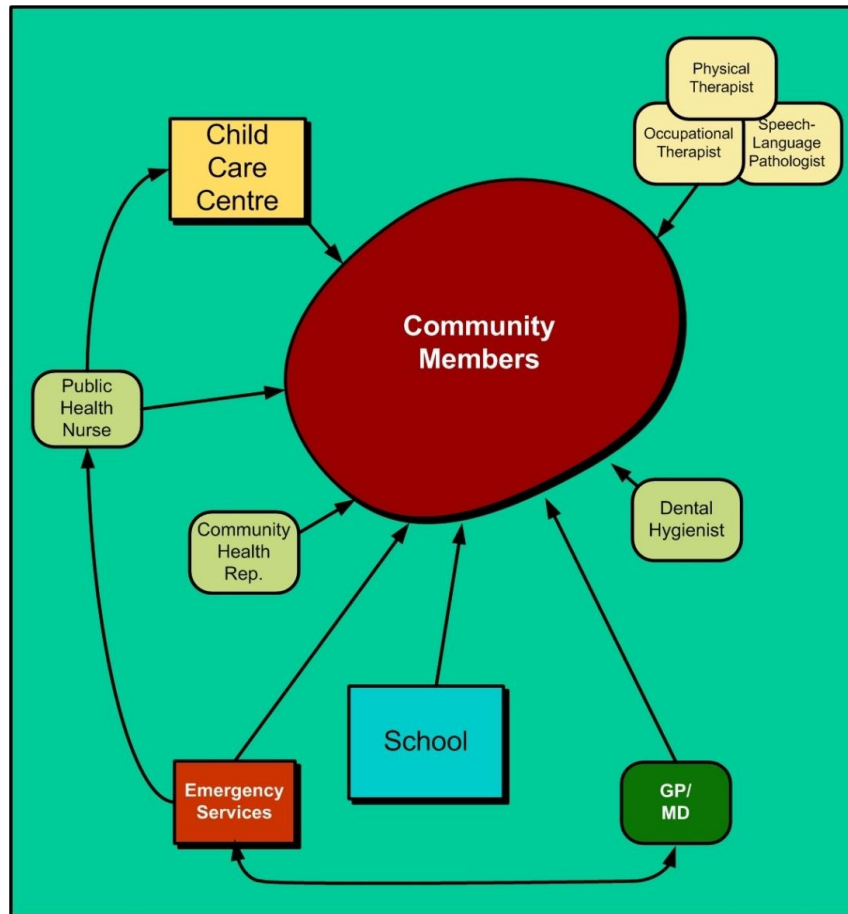


Figure 1. Prevalent individual-centred, problem-driven, fragmented service model.

A report on current service provision in Canada's hinterlands concluded that the fragmented system of social, health, and education services is the most significant barrier to population health in rural, northern, and First Nations communities (de Leeuw, Fiske, & Greenwood, 2002). Similarly, a report of an Aboriginal leadership forum in British Columbia noted that, "Current government programs—a patchwork at best, fractured among various levels and departments of government, often inaccessible to those with the greatest need, and not reflective of Aboriginal values and culture—have done little to undo almost a century of damage" (BC Aboriginal Child Care Society, 2003, p. 3). The lack of access resulting from this fragmentation has also been identified by Leitch (2008) in her analysis of contributors to health inequities for the federal minister of health.

In the common fragmented model, ECCD programs are usually evaluated in terms of direct benefits to individual children, such as the development of pre-literacy and language skills, socialization, and school readiness. Other programs and services for children, such as speech-language therapy, audiology, immunization, dental and vision screening or supports for special needs, are usually seen as separate provisions funded by different agencies, provided by distinct professions, and evaluated in terms of discrete outcomes. Because there is no cultural or social mediation of interactions between community members and service providers, everyone is at risk of cross-cultural communication breakdown. Continuity of care or coherence among services provided to a child or family are not typically used as criteria for evaluating services, because these would require coordination across jurisdictions, which is not provided by the

bureaucracies that fund service delivery. Outcome evaluation does not assess the well-being of the "whole child" within her or his family context.

Many administrators of Indigenous communities have expressed frustration with this model in which individual service is based on a specific "need" or "problem," rather than on the functioning of the "whole person." The fragmented model sets up real challenges for contracted specialists from outside the community in "reaching" individuals in the community, while community members have similar difficulties in "finding" the specialists. Professional service practitioners who were interviewed for the current study described how simply finding a community member who has been referred to a service, such as supported childcare, screening, diagnosis, treatment or rehabilitation, is often their biggest hurdle. Service delivery ends up depending on the initiative, persistence and resources of both the individual community member and the service provider.

In countless forums and meetings, Indigenous leaders and community-based practitioners have described how, in a fragmented system that depends on having separate specialists to meet needs that are conceived as separate targets, service memory is lost when professional staff leave the community or are assigned elsewhere. There is an extremely high turnover of professionals serving Indigenous communities, particularly in the northern regions of each province and in the Canadian Arctic. Community-based program administrators and external service providers interviewed for the current study explained that when service providers work as a team rather than alone, and in an integrated rather than fragmented way, then the knowledge of the needs, goals and service history of children and families is retained and passed along within a community-based family support team—leading to continuous and better coordinated services.

### **Call for Intersectoral Service Delivery**

There is a voluminous international literature advocating "intersectoral" and "integrated" service delivery for promoting maternal and child health, growth and development (e.g., Haddad, 2001; Myers, 1995; United Nations Children's Fund, 2001; Woodhead, 1996). The World Health Organization (Bell, 1997), Romanow's (2002) Commission on the Future of Health Care in Canada, and the Canadian Population Health Initiative (2004) have all called for intersectoral approaches that address the many non-medical determinants of health—including early childhood development, environment, working conditions, lifestyle, social status and governance. The World Health Organization (Bell, 1997) has long called for (a) funding demonstration programs, (b) training that prepares people to work in multi-disciplinary teams, (c) research that expands definitions and criteria for measuring health, and (d) program evaluation that identifies promising practices for improving well-being and quality of life.

In 2002, the Romanow Commission was appointed by the federal government of Canada to provide a status report on health care in Canada and to offer direction for the future of health care (Romanow, 2002). The Romanow Report—the first national health status report ever to devote specific attention to Aboriginal health—concluded that the state of health and well-being, and the conditions of life for Aboriginal people in Canada, were inexcusably low. To address this, the Commission argued in favour of culturally defined concepts of health, consolidated funding, and pilot projects funded across jurisdictions that encourage flexible, community-driven, "one-stop" models for promoting well-being and providing intervention services. The National Aboriginal

Health Organization (2002), supporting First Nations, Inuit, and Métis Peoples' wellness, is quoted as submitting to the Commission that, “. . . one of the essential ingredients in creating effective Aboriginal health systems is a multi-jurisdictional approach to health service reform” (p. 224).

In provincial and regional meetings of Indigenous leaders discussing ways to strengthen the capacity of their communities to create and operate new services or to take over staff positions in existing services, a point repeatedly heard is that Indigenous people want to learn from the mistakes of non-Indigenous systems of government and community development. Specifically, they do not want to replicate the fragmentation and some of the inefficiencies of mainstream social services, health care, and community development in Canada. A representative of one of the regional inter-tribal health authorities in British Columbia put it this way:

Yes, we need training. But what do we want to train our people to do and to become? The transition to Aboriginal control should not mean simply Aboriginal people taking over White jobs, doing things in White ways. We want to do things in Aboriginal ways. We need training that will support our members in remembering their cultures and creating Aboriginal services that are really Aboriginal. (R.M., personal communication, 2005)

Unfortunately, the international literature offers few inspiring examples of applying the rhetoric of intersectoral coordination and integration in practice (O’Gara, Lusk, Canahuati, Yablick, & Huffman, 1999). Chronic disappointments in moving forward on the intersectoral agenda in Canada and abroad can be attributed to a number of political, conceptual, and practical barriers, including (a) the hegemony of European-heritage worldviews and forms of governance; (b) reluctance to share authority over health care expenditures and accountability for health outcomes with communities; (c) anachronistic, fragmented bureaucracies; (d) competing theories about the determinants of health; (e) a persistent emphasis in health theory, research, and practice on the individual as the unit of analysis; (f) reliance upon physicalistic interpretations of health status and health care; and (g) professional turfism. Given these substantial challenges, the innovative approaches of the First Nations participating in the current research are particularly worthy of examination.

### **Three Case Studies**

A documentation research study followed up three groups of First Nations community members four years after these communities had completed a partnership program with the University of Victoria which involved the community-based delivery of a bicultural (Indigenous and Euro-western), university-accredited diploma program in child and youth care. This program, called the First Nations Partnership Program, focused mainly on ECCD (Ball & Pence, 1999, 2006).<sup>3</sup> In 1999, 35 members of the three groups of First Nations completed the two-year post-secondary education program. Four years after the training program ended, First Nations administrators wanted to measure the results of their investment. The author, based at the university and currently serving as the

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<sup>3</sup> For more information on First Nations Partnership Programs, see [www.fnpp.org](http://www.fnpp.org)

coordinator of the First Nations Partnership Programs, wanted to determine whether a training program that is unique in the degree of emphasis it places on Indigenous knowledge and preparing students to respond to local needs and goals, would actually lead to the development of programs and practitioners that are uniquely suited to local understandings of child development and their place within their families, cultures and communities.

Fourteen First Nations in British Columbia participated in the follow-up research. These communities range from 100 to 1000 members. Geographically and organizationally, they form three clusters. Six First Nations that make up Treaty 8 Tribal Association are located in the northeast of the province. Tl'azt'en Nation is located in the centre of the province. Mount Currie First Nation [hereafter referred to as Lil'wat Nation, by which the group of communities is now known] is comprised of several small First Nations nestled together in the mountains north of Vancouver, in the southwest of the province (see Figure 2).

A total of 76 people from the three groups of communities participated in the research, through interviews, questionnaires, and group fora. Review of program manuals, policies, and utilization records, as well as direct observations were also used. Data collection was aimed at gaining a profile of community-based programs that had been implemented with the help of training program graduates, understanding how these programs were funded and organized, and how these programs were reaching out to infants, young children, and parents in the community. The research also explored how the communities had achieved program implementation, including the challenges, benefits, and next steps.

The research found that 33 (94%) of the post-secondary program graduates were working in their own communities, most in career-relevant jobs, such as infant development, supported childcare, preschool, and Aboriginal Head Start. Many graduates had created new programs and new roles within existing programs. All three community groups had taken significant steps, suited to their circumstances and opportunities, to build community-based infrastructure and intersectoral linkages to support the holistic development of young children and their families.



Figure 2. Map of British Columbia showing locations of case study communities.

### Moving Towards Coordination and Integration

The approach in all the communities that participated in the research has been to increase access to services in a number of ways, not just through geographic proximity to families and by providing financial subsidies, but also by ensuring “cultural safety”<sup>4</sup> and services that meet the particular needs and preferences of community members. They have all embarked on long-range plans that move away from the typical non-integrated model and towards models that (a) integrate child health and development programs on-site in their childcare programs; and (b) create clear operational links between their childcare

<sup>4</sup> Cultural safety is a term that is sometimes used to capture the sense of feeling socially safe to express one’s views and behave in accordance with one’s own culture, without risk of being scorned or made to feel socially alien. Formalization of the concept of cultural safety began in 1988 at a *hui* in Christchurch, New Zealand, attended by nurse educators and Maori student nurses (see Dyck & Kearns, 1995; Papps & Ramsden, 1996).

programs and other health, cultural, and social programs intended to benefit children and/or parents (see Figure 3).

### **Case Example 1: Treaty 8 Tribal Association**

The six First Nations that are represented by the Treaty 8 Tribal Association range in size from 70 to 205 members. They are culturally diverse and geographically dispersed, and are located from two to seven hours drive from Fort St. John with a population of 16,000 people. The First Nations in this Association sponsored 15 community members (two or three students from each community) to live in or near Fort St. John in order to take the ECCD education program. By the time the students graduated, three of the First Nations had developed new facilities and new services for children, and two more were able to use existing educational facilities to mount new childcare programs. One community was not able to develop services due to other pressing priorities. There are now two Aboriginal Head Start programs located in Blueberry River and Saulteau First Nations—two of the smaller communities—both staffed by program graduates.

Coordination of services delivered across these small rural communities is eased by the relatively small number of community members and visiting specialists involved. The communities have a school near their largest on-reserve population centre, as well as a childcare centre and a health care centre consisting of three or four small offices, where they have effectively clustered similar services together. Some service practitioners, including childcare centre staff, teachers and community health representatives, live and work in the community, and are mostly First Nation community members. Other service practitioners exist as satellites to the community, but they are more readily able to access clients—and community members are more readily able to access them—through the community-based service offices. ECCD programs and specialist services remain essentially fragmented, however, with regards to sources of funding, service mandate, scope of practice and accountability requirements. Administrators in these small, relatively remote communities pointed out the special challenges facing communities with a very small population base, especially when funding is allocated on a per capita basis, which limits their ability to realize a broader range of integrated, community-appropriate services. The Education Coordinator of the Treaty 8 Tribal Association, Diane Bigfoot, who also oversees transitions from training to work, spoke of the ongoing effort to strengthen ECCD capacity:

The training in early childhood care and development brought forth more programs—not only childcare—but for children and families, and it brought these to the communities. This is still growing. Two of the First Nations just started a childcare and development program—expanded beyond the Aboriginal Head Start program. They are sharing, and this sharing is also an outcome of the communication and understanding that developed between people who were originally students in the post-secondary training together. It is good to see the communities working together in this way. The presence of trained community members in the communities keeps attention focused on the importance of children and youth and culture—and there are all sorts of programs running—even if the administration changes or the political level is turbulent, the services continue. This is very important. (Diane Bigfoot, cited in Ball, 2004, p. 2)

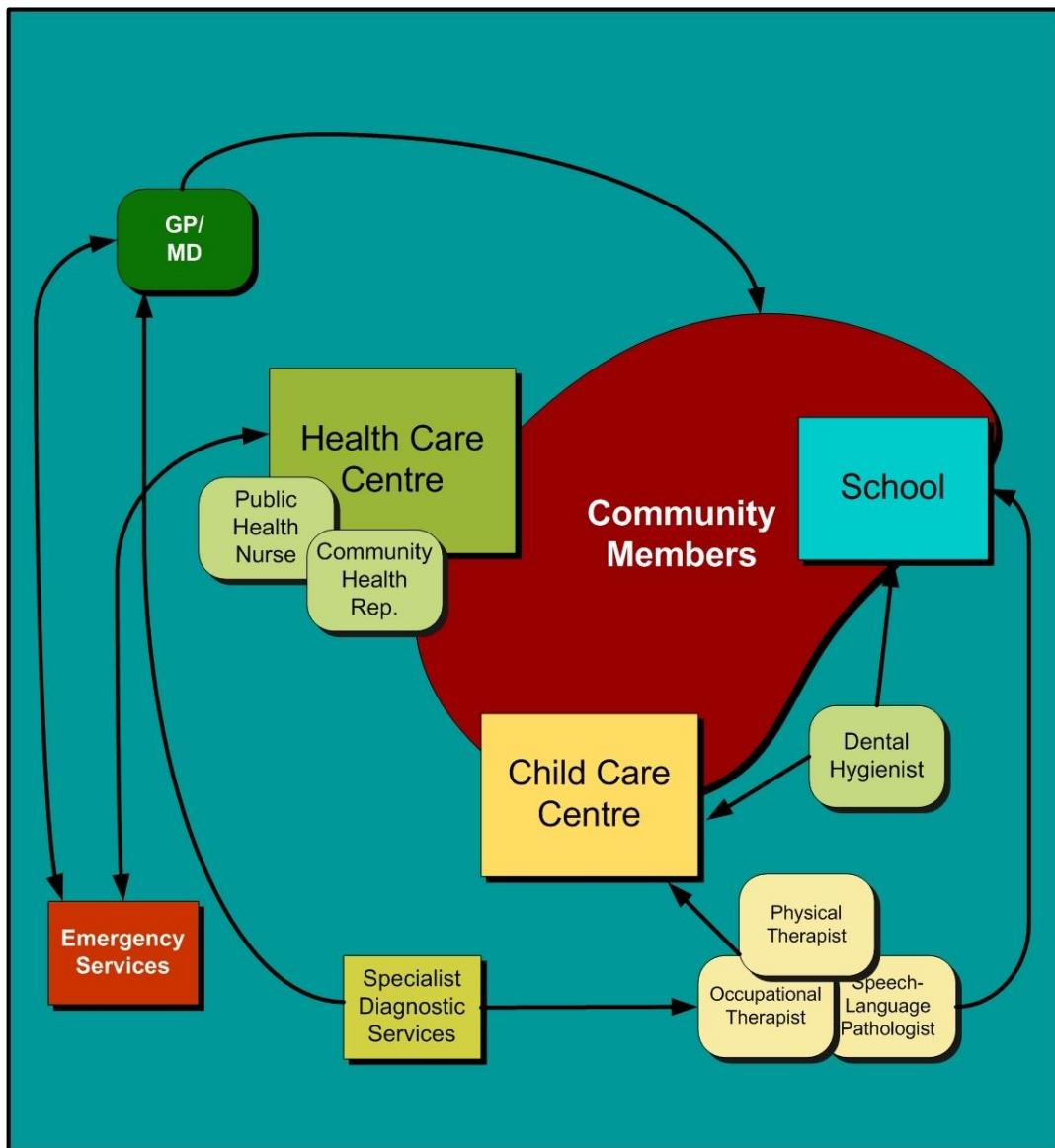


Figure 3. Emerging community-based service model in small communities

### Case Example 2: Tl'azt'en Nation

Tl'azt'en Nation consists of three small communities with a total of about 680 members who share the same culture, language, and history. Like much of the population in the northern half of the province of British Columbia, members in these communities may wait years for on-site screening, diagnosis and early intervention services. Most specialists are located in the city of Prince George—three hours drive away in good weather.

Before the post-secondary education program commenced, this First Nation received funding from Health Canada and other sources that enabled them to construct a licensed childcare facility in an unused wing of the school located in the largest on-reserve population centre of Tache. When 10 community members completed the ECCD training program, most of the graduates were involved in opening the new facility, and

they began to offer a full-day child and development program called *SumYaz*, or Little Star, in the community for the first time, along with other services are integrated directly into the program. A short time later, the community received funding to innovate an Aboriginal Head Start program delivered in a facility on the school grounds.

Both programs are run entirely by credentialed community members. Both have received excellent evaluations both from the regional Early Childhood Education licensing officer and from the Aboriginal Head Start Regional Headquarters. Children come by bus from the two smaller villages of Binche and Dzitl'ainli, 20 to 45 minutes away, to attend the school, the childcare program, and Aboriginal Head Start. ECCD practitioners, community administrators, and contract service providers described how the childcare facility and the Aboriginal Head Start facility are used as sites for the integration of services, noting that this enables (a) access between specialists and children and parents, (b) development of "service memory" among staff, (c) multidisciplinary professional development for on-reserve staff, and (d) cultural learning for visiting specialists (see Figure 4).

The community decided to locate health services, adult counseling, and alcohol and drug treatment services in a different area of the village than the school, childcare centre, and Aboriginal Head Start facility. Administrators and ECCD practitioners explained that this was intended to prevent the spread of illness and to provide some "children only" space set apart from community facilities for adults involved in treatment, recovery programs, and social services.

The community champion of the ECCD training program and the community development strategy for innovating a growing number of coordinated services for young children, Amelia Stark, Director of Education, emphasized supportive community leadership as an enabling condition of ECCD initiatives in the community.

The biggest benefit of training for our community has been the opening of a number of new services for young children and their families, such as the SumYaz Daycare and the Aboriginal Head Start. There is good support in the community for this initiative. An important part is having a good Education Society made up of concerned community members with a vision. (Amelia Stark, personal communication, 2002)

This community leader further identified leadership development as an outcome of the ECCD initiatives in the community.

The second major benefit is the program helped our students in the community to find their voice. They were a shy bunch of ladies; today they have the confidence to work with community members and our Elders. They gained skills on how to work with Elders, which is an important component in Tl'azt'en Head Start program. The CYC [Child and Youth Care] students have the confidence, education and capacity to deliver a well thought out program for the children. They will one day become true leaders in our community. Two of the students are holding manager positions and all are employed. They are well recognized and respected in our community. The women are building the foundation with the families, where they are moving forward now to become leaders. We are proud of their accomplishments; the program was worth the energy

and commitment. (Amelia Stark, personal communication, personal communication, 2002)

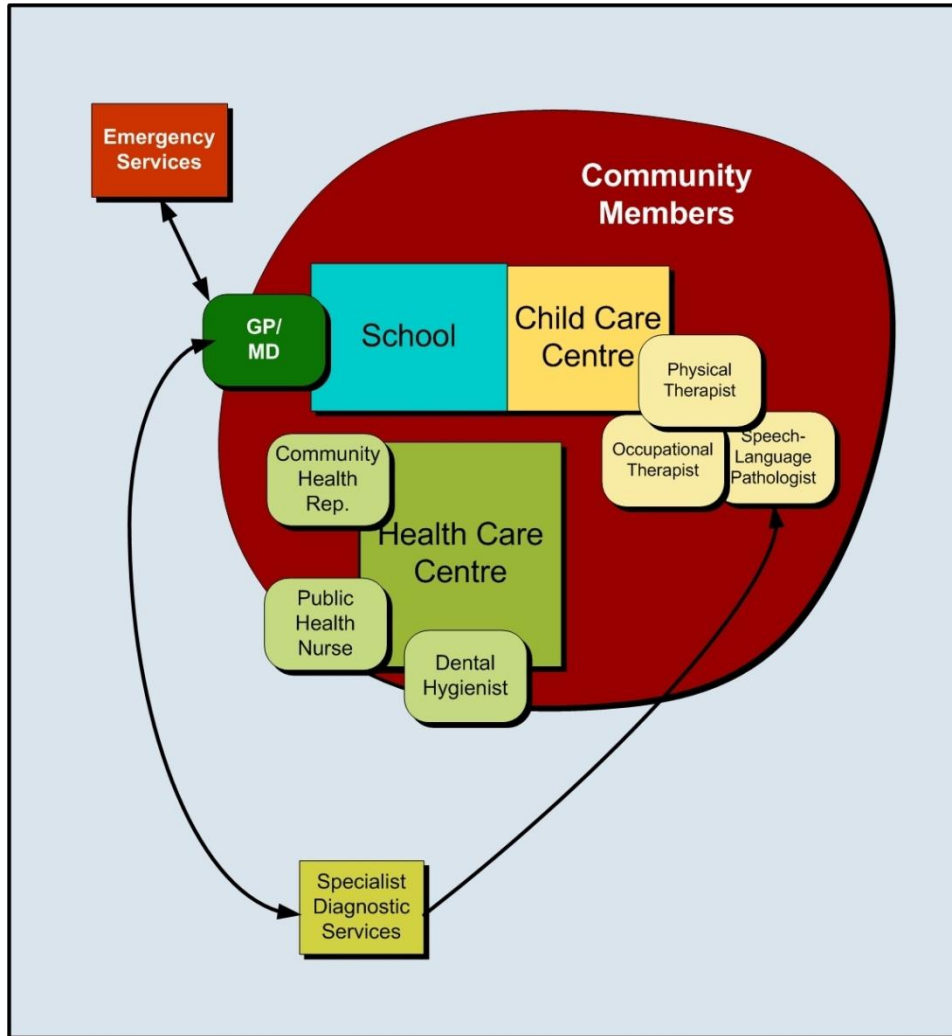


Figure 4. Community-based service model with school as integration site for selected services.

### Case Example 3: Lil'wat Nation

Lil'wat Nation, situated in southwestern British Columbia about two hours from the urban centre of Vancouver, has the largest population base among the communities participating in the research. It consists of one main community of about 1,000 members and four other affiliated communities with a total of about 800 members. The communities share a band-operated school offering Kindergarten through Grade 12 and many other services. Together they have established a well-developed planning structure, stable leadership, and a long history of successful development initiatives.

In the mid-1990s, the community decided to plan for comprehensive childcare programs, involving integration and intersectoral services and incorporating cultural values, cultural literacy, and heritage language. Their goals were both to enable parents to participate in healing programs, continued education, and employment and to support the development and positive cultural

identity of young children. They had a community-centred concept for services to families, beginning with quality childcare delivered by credentialed community members in a licensed setting as the “hub,” as shown in Figure 5.

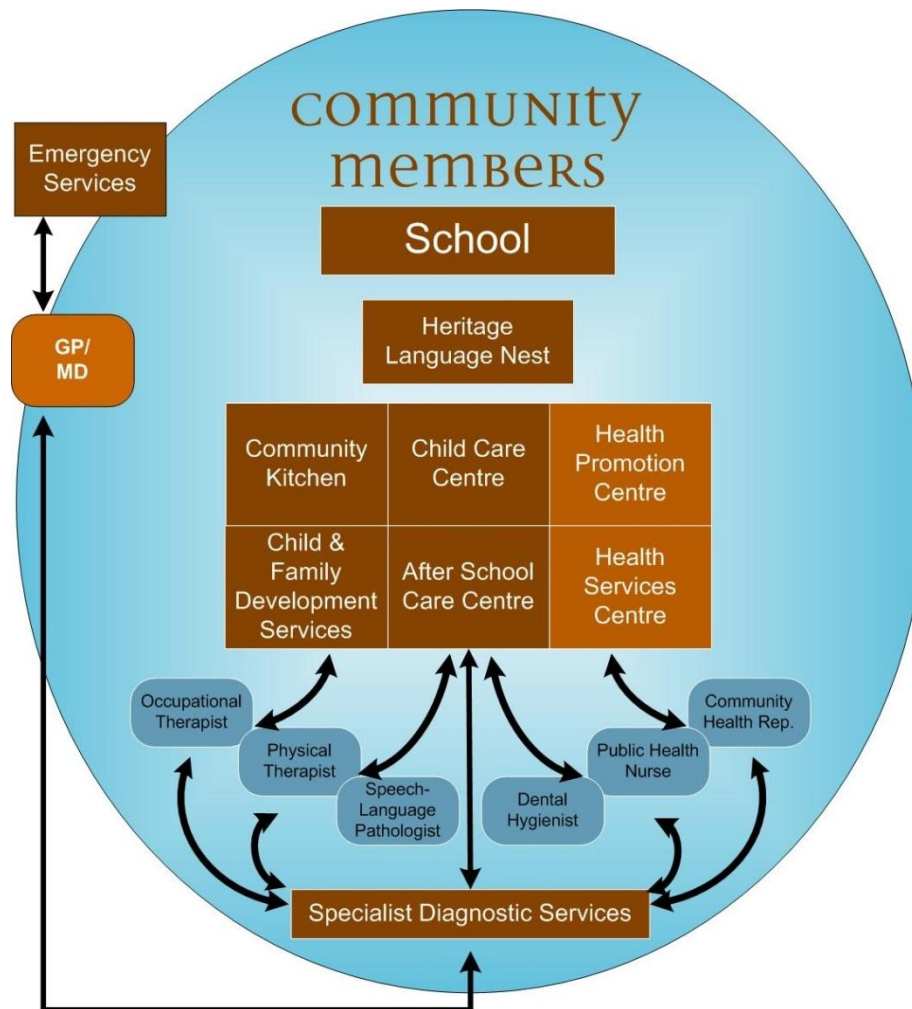


Figure 5. Community-based service model with childcare as integration site.

Lil’wat Nation sponsored 15 full-time community members to enrol in the early childhood care and development training program. In 1999, just as 14 students were graduating, the community opened a new multiplex facility, called *Pqusnalhcw*, or Eagle’s Nest, strategically located only 200 metres from the full-service, band-operated school. The multiplex provides Elders and children with a culturally vibrant gathering place that promotes health and wellness of the whole community. The multiplex houses a large preschool program, called *Skwalx*, or Baby Eagle, and a large infant care centre called *Tsepalin*, or Baby Basket. Most recently, the community opened a large after-school care program that is partially integrated with the childcare programs, sharing some staff, activities, outdoor play space and equipment. They also added a health service wing, examination room, and staff room. Over time, the services delivered inside the childcare centre itself have evolved to include occupational therapy, supported childcare, developmental monitoring, assessment and referral, speech-language pathology pre-

screening and monitoring, and preventive dentistry. At the time of this report, the combined childcare programs served 120 children from 6 months to 6 years of age.

Co-located in the same multiplex are a community kitchen, health information and promotion area, health services offices with examination rooms, and multi-purpose rooms offering a range of family services. The multiplex functions as a site for the integrated and co-located delivery of a range of health and social services, including alcohol and drug counselling, tobacco reduction and diabetes prevention, as well as infant and toddler care, preschool and after-school care, and parent support programs such as Best Babies and language facilitation training.

### **ECCD Programs as Hook and Hub**

Each First Nation that participated in the research had taken the first planned steps towards community-based, culturally informed supports for young children's development and streamlining access to specialist services. Although each community was going about service development differently, all administrators and practitioners expressed their satisfaction with their progress to date and their belief that they were incrementally building services that (a) ensure that children in their communities receive quality childcare; and (b) effectively "hook" parents, other caregivers, Elders and community administrators not only to bring their children for childcare, but to "ladder" into other activities, services and programs, including language, nutrition, health, social development and cultural programs, built like a hub around the childcare.

### **Hooks**

Many families need and want quality childcare services for their children. In these First Nations communities, that need or desire acts as a magnet to attract or hook family members in to the childcare program. When community leaders held forums for their members to discuss the idea of making ECCD a focal point of community capacity building and infrastructural development, the value of assuring quality care for babies and preschoolers was an easy hook for mobilizing positive community action. Many of the childcare staff interviewed for the research described how parents are often willing to seek playmates for their children, respite from the constant demands of parenting, or reliable daycare so they can work, whereas they may not be so willing to seek supports or services for themselves or for other family members. Once they begin bringing their child to the centre, family members learn about other programs, services, information and special events available to them and are encouraged to ask for the kinds of supports they need to promote wellness of all their family members. Parents in the participating communities described how they began by bringing their children for care, and then expanded their involvement by accessing other, co-located services for other children of all ages in their care. Over time, as they became comfortable with the staff and the quality of care and felt safe within their own cultural context, they came for social support and services for themselves.

Other hooks for securing the attachment of families to comprehensive community-based supports for achieving wellness include (a) having community members involved in the ECCD programs as guest speakers, mentors, planners and helpers in other community events and service boards; (b) co-locating programs with cultural meeting places and community kitchens; and (c) holding events such as open

houses and family days that welcome the whole community. For example, in several of the First Nations in this study, childcare programs are co-located with Best Babies programs, Mom and Tot groups, Parent-Child Mother Goose, language facilitation programs, nutrition ,workshops, hands-on displays about healthy living (for example, diabetes prevention, exercise, medication) and similar programs to promote child and family well-being. When parents bring their child for care, they pick up information about other programs available, and may see other community members attending these programs. Staff in the centre get to know the parents, and may draw their attention to a particular program being offered. Gradually, parents become more involved, and many volunteer to help in the community kitchen or to spend time with children in the childcare program. After a period of familiarization and developing a sense of safety and trust in the staff, they enroll in a program for themselves. As one community member remarked:

Ever since this place happened, I feel like people can come out more and get the help and support they need. This childcare program has been like a magnet that has drawn us to get together and keeps us here, doing things to help and heal ourselves and that will hopefully make our community stronger and a better place for our children and everyone who lives here and even those who want to move back here. (L.B., personal communication, 2002)

### **Ladders**

Childcare staff and administrators in each of the three community sites explained that, because of the community's ability to offer a laddered system of services, the community can often assist vulnerable children without disrupting family life. Child welfare practitioners are less likely to resort to invasive monitoring or calling in external child protection services that often result in stigmatizing "pull-out" programs or apprehension of children into government care—an all too common occurrence in First Nations families. The manager of one of the childcare programs explained:

We probably know families in our community better than anyone. We see the children every day, or if we don't see them every day, we know something must be going on. And we see the parents every day, and we begin to be able to tell how they are doing, or if they're having some difficulties. Or if we don't see them bringing their child or picking them up, we might start to wonder why—where they are. So we have this kind of "alert" system about the family. And if we think there is something more that the family is needing, we can work on putting systems in place to provide some extra support for the family during hard times, or refer people to treatment, or get some extra services in place for the child if that is what's needed. (D.F., personal communication, 2002)

In another community, the director of the multi-service centre explained:

. . . parents can move from a Best Babies or other parenting program into supportive counseling while their infant is cared for in the infant centre, and then ladder into more intensive personal wellness programs, such as Residential School recovery support groups, alcohol and drug treatment services, and employment search and job training. (Jessica Frank, personal communication, 2002)

A parent recounted her experience of this laddering function:

My daughter has special needs. She gets supported childcare in the centre as well as speech therapy. Because of having a licensed childcare program with really good staff who I know all of them personally, I was able to pursue my education and now I am in job training. I couldn't have done these things without the different kinds of programs offered in addition to childcare at the centre. (N.H. personal communication, 2002)

Childcare practitioners are able to help identify children who might benefit from diagnostic assessment to determine the need for early intervention for specific developmental delays. In one community, staff described how they sometimes prompt a parent to think about taking his or her child for diagnostic services. These staff said they have also, on occasion, stepped in themselves to arrange on-site diagnostic assessment for a child.

## **Hubs**

The hub model now in use by the First Nations involved in this research is essentially a family- and community-centred, rather than a child-centred, model of service delivery. It is both holistic and population-based, with services specifically designed to meet the needs of the local population for developmental, social, primary health, and cultural programs, as well as for supports for children with special needs and children in vulnerable families. By setting up their childcare centres as the focal point or hub of a larger system of community programs and meeting spaces, these communities have managed to create a service delivery model that is not only multidimensional and accessible, but also culturally appropriate.

Community leaders and program staff explained to us how they see the family as the central organizing focus for delivery of services, and the well-being of young children as dependent upon and also contributing to family well-being. Many community members spoke about the concept of the “early childhood years” as a foreign idea that artificially segregates young children from “all children” or “the whole community.” As one First Nation Elder said: “Our children need to be understood as part of a whole that includes their family, community, culture, and the natural environment” (Martina Pierre, Lil'wat Nation, personal communication, 2002). In these communities, the childcare facilities are now primary sites for bringing people of all ages together and holding cultural events, as well as providing services and programs directed at addressing the well-being of the whole child and the whole family—including information and education, social support, health services, and speech-language services. A grandmother who regularly brings her grandsons to the child development programs explained: “Our childcare is a holistic model, and feels natural to us as Aboriginal people, where we have always seen children and the community as one. Children are the future of our

community—they are, or they should be, the centre of everything we do” (V.K., personal communication, 2002).

The hub model reflects a holistic, community-driven philosophy and provides for service delivery that is consistent with Aboriginal ways (see Figure 6). It also increases:

- cost—and resource—efficiency;
- increased social support and engagement for all community members;
- laddering of services for children and families, especially those at risk;
- access by service providers to individuals in small communities;
- inter-professional communication;
- program stability and continuity of services;
- community-wide involvement and support; and
- community capacity through ongoing, multidisciplinary teamwork and leadership.

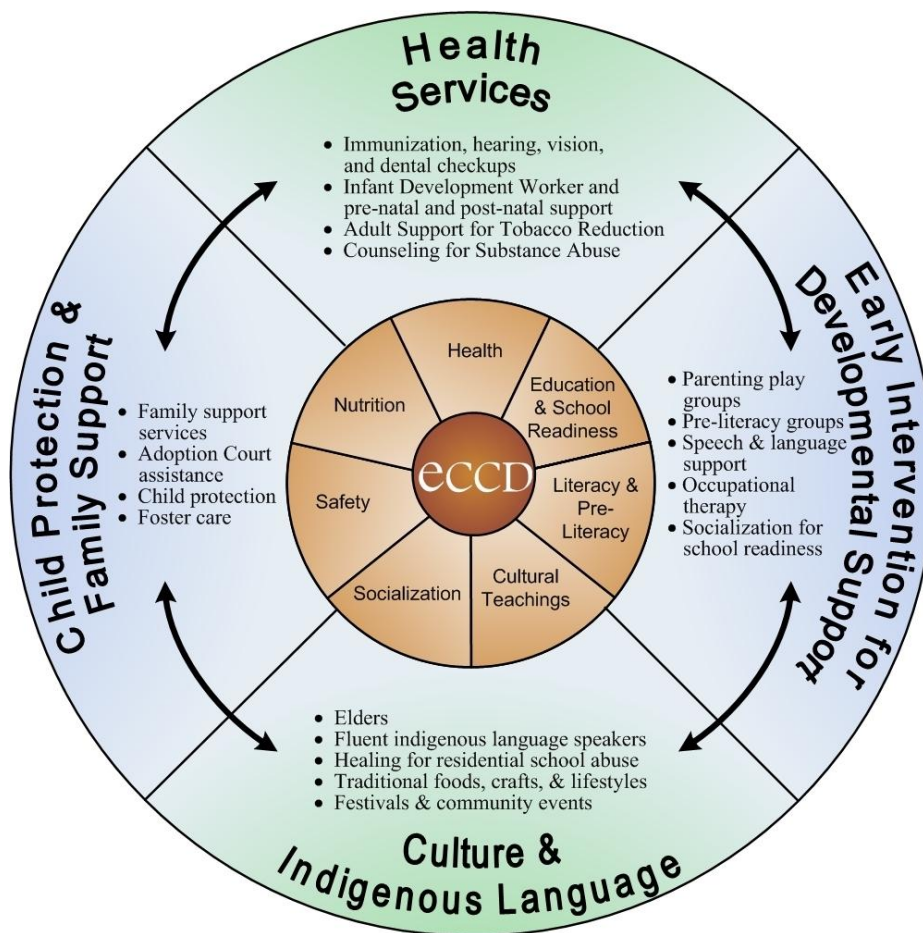


Figure 6. Early childhood care and development as a community-based hub.

### Leadership

The design and delivery of new programs in these First Nations are illustrative of the benefits of long-term, comprehensive visioning and planning, good governance within community, and a steadfast commitment to the well-being of the youngest generation as a

priority for community development. The Director of Community Advancement Programs at Lil'wat Nation, Christine Leo, gave the following explanation.

Lil'wat Nation strongly believes in Aboriginal title and rights, and our sovereignty over our lands. We need to provide support for families and specifically for young children, and especially for families that are having trouble caring for their young children. . . . Another value is that we want our children to have cultural training. A few years ago, we did a labour analysis and needs survey and our first priority was post-secondary training in early childhood, so that we could establish our own daycare, operated by our own people, carrying on our own traditions and values. We have done that. Parents are happy when their children go to this childcare program. They develop good habits, have good nutrition, early learning, especially cultural learning, and socialization. We have support from the Chief and Council and administration here, and the staff who graduated from the post-secondary program with UVic are very happy to be working in our own community. The different departments here work together—the Health, Childcare, Education and Training, Wellness, Economic Development, Social Development—we all work together and that contributes to the success of our programs. (Christine Leo, cited in Ball, 2004, p. 1)

### **Training Focusing on Particular Community Needs and Goals**

The participants in the follow-up research described how the *kind* of training a community makes available to its members affects both the graduates' and the community's readiness to make the transition from training to work. The education delivery model used in the First Nations Partnership Programs is community-based, community-driven, and community-involving. The curriculum builds on community-specific cultural knowledge and ways of supporting young children's well-being. Participants in the follow up research described how these features of the training program ensured that program graduates became able to deliver the culturally consistent services and supports that community members need, accept and appreciate.

### **Aboriginal Ways**

Throughout the two-year post-secondary program, members of the participating communities discussed the meanings of child and family wellness within the historical context, culture, and lifestyles of their own people. Across all the communities, the themes of holism and community-centred development were returned to again and again.

**Holism.** In these First Nations, child development is viewed holistically, with the many aspects of a child's body, mind, and spirit, as well as their past and their future, seen as intertwined and requiring recognition, nurturance, guidance, and respect. This view permeates community decisions about what childcare and development programs should entail, for example, a proactive, developmental approach to the whole child that includes nutrition, preventive health, socialization, education, Indigenous language and culture. This approach is consistent with a national call for integrated and intersectoral coordination (Romanow, 2002).

**Social inclusion.** A First Nations Elder explained in a research interview how concepts that distinguish children according to age, stage, or abilities are not meaningful and not wanted in her community.

The idea of early childhood and ideas like disabled children, or that some children have special needs and some children are gifted—these ideas don't come from us. They are not Aboriginal ideas. They come from white people, and from cities. All children have gifts and are gifts from the Creator. We don't like to box people up and separate them out. We've seen how that can be used as a way of getting rid of people, of boxing them up and shipping them out, out of the community to special schools, or what have you. Until we were forced to send our children away to school, we always kept all our children with us, and all together, in families, and we want that again. (Marie Leo, Lil'wat Nation, personal communication, 2002)

This statement, combining the themes of holism and inclusion, as well as a lifespan perspective and spiritual convictions, sums up many statements made by participants referring to “all the children”, “all together” and the desire to create a welcoming centre in the community that many people would experience as a kind of home and family.

**Community-centred development.** The goal of improved community conditions for children's health and development was seen by community leaders and students as dependent upon the goal of supporting family wellness. Thus it was conceived that ECCD programs should reach out to secure the active involvement of parents, grandparents, aunts, uncles, and others who care for infants and young children. As a childcare practitioner in one of the communities said:

Parents in our community either were forced as young children to leave home and grow up in residential school or were raised by parents who grew up in residential school. Many never had a chance to experience childhood themselves. They are just beginning to heal, and just beginning to learn how to be parents. When a child comes back [to our centre] on Monday morning, we can usually tell how the parents are doing, and what's been happening over the weekend. (D.H., personal communication, 2002)

A goal of the ECCD strategy in these communities has been to provide a respectful, culturally safe, socially supportive centre for parents and guardians, not only to access childcare, but equally importantly to strengthen their confidence and competence in supporting their child's optimal development. They are consulted about how their child is developing and they are offered opportunities to participate in the childcare program and to attend a range of programs such as health education, cooking and household budgeting, parent education and support, residential school recovery and healing programs, community events, and service referrals as needed.

### **Promising Practices**

The communities whose visionary work is highlighted in this article share a goal of addressing a range of needs and goals for children through the provision of a range of

accessible direct services, as well as through improved cultural, social and physical environments for child and family development, all within a culturally congruent, community-centred development model. These promising practices show how good governance, forethought, ingenuity, and an ability to think holistically can create service systems that are tailored to the culture, circumstances, readiness, needs and goals of their own populations.

Each of the communities is different, and the documentation research found variations in exactly how each is able to support the whole child within the context of their family and community. Communities with a larger population base have more funding, more trained community members, and often a larger group of core leaders in governance and community development, enabling them to implement more comprehensive, community-based programs. Communities with smaller populations—especially those that are geographically remote—have less funding, especially when funding levels are determined on a per capita basis. They have a difficulty gaining access to training that meets community needs, attracting and retaining practitioners, and providing mentoring and professional development for program staff. As the Romanow (2002) report points out, the issue of how to support children and families in smaller and more remote communities across Canada is a challenge that calls for national dialogue and changes in both policies and funding priorities. Many small communities are less ready to articulate their own goals for community development and often do not have the leadership or resources to advocate effectively for resources or to implement long-range plans for community-based services. In the current research, the small communities in the Treaty 8 Tribal Association are finding success through collaborating with neighbouring communities to coordinate programs and services.

First Nations in Canada are diverse, and any one vision, plan or model will not be applicable for all: There are no “best practices.” The Romanow (2002) Commission and the National Aboriginal Health Organization (2002) both emphasize that service delivery models and programs must be adapted to the differing realities of different communities. Capacity-building initiatives must be anchored deeply within each community’s own socio-historical context, geography, culture, resources, and vision. Community members need to be involved directly in defining the services that they need *and* how to organize and deliver them. Respecting that there are many paths to achieving the goal of community-centred services, most Aboriginal communities advocate holistic approaches to child and family well-being which require partnerships among service sectors and among communities in order to work. Myers (1995), one of the leading proponents of integrated supports for child well-being, points out that the goal of supporting the development of the whole child is to develop an integrated response to children’s needs, regardless of whether services themselves are integrated.

The participating First Nations are working on long-term, comprehensive community development plans similar to the “comprehensive community initiatives” discussed elsewhere in Canada as promising approaches to poverty reduction, community revitalization, and sustainable development (Torjman & Leviten-Reid, 2003):

Comprehensive Community Initiatives are holistic, developmental, and long-term. They are multisectoral and seek to be inclusive. They are concerned with both process and outcomes. . . .They seek to create opportunities for individuals and families to improve their lives in many different ways. Various projects may be undertaken to ensure access to

nutritious food, provide training that will help lead to decent employment or promote access to high-quality, affordable childcare. (p. 2)

### **Intersectoral Coordination and Integration: What Are We Waiting for?**

This article emphasizes the benefits, and what it takes, to move beyond the rhetoric of holistic and integrated services to engage incrementally in steps that hold promise for a joining together of services across sectors, across professional disciplines, and even across cultures. There is strong belief—among many Indigenous and non-Indigenous peoples—in the holistic nature of child development, and there is abundant evidence of the multiple, ecologically inextricable determinants of health. While the community examples highlighted in this article show that it is possible, with enough determination and ingenuity within a community, to get beyond the rhetoric of integration and coordination to make it happen on the ground, documented success stories such as these remain scarce. For First Nations that are blazing new trails for communities across Canada to realize their vision of comprehensive, community-centred strategy to address children’s development holistically and contextually, the path has not been smooth. Participants in the research identified many sources of frustration—for example, with the duplication of grant applications and accountability requirements, over-specialized training programs, premature termination of funding for pilot programs, and the tendency towards competition among departments in their community. If integration and intersectoral coordination makes so much sense, why are we not doing more of it? What are the barriers? Whose needs are being served by perpetuating top-down, expert-driven approaches that reproduce fragmented patchworks of programs and services? Institutions need to work cooperatively across professional disciplines and jurisdictional boundaries, streamlining both access to resources and accountability requirements. Further, they need to engage in supportive, long-term partnerships with communities that will enable the communities to evolve and to implement creative approaches over time.

Despite the challenges, the First Nations in this research demonstrate strong leadership, political will, creativity, cooperation and persistence. By vigilantly pursuing opportunities, they have overcome some of the obstacles that typically hinder the development of comprehensive, integrated systems of early childhood care and development (Haddad, 2001). Key learning points from documenting the journey of these successful First Nations are summarized below.

#### **Programs Embody the Culture(s) of Intended Beneficiaries**

Programs to promote child development and address developmental challenges must be culturally congruent in order for people to participate. Childcare and development programs are an effective “point of entry” for families to become involved in systems of support and intervention to improve the health and well-being of all family members. For Aboriginal peoples, children’s well-being is a strongly held cultural value. Aboriginal peoples, in particular, need to see their cultures reflected in the people and places providing services and in the action steps suggested for maintaining or improving child development.

#### **Community Capacity Develops Incrementally Over a Long Time**

Aboriginal peoples have been devastated by colonial practices for centuries. It will take time for Aboriginal communities to rebuild community capacity. Strengthening community capacities and securing the hard and soft infrastructure for a range of integrated services take time. Funding and program evaluation need to support long-range planning and incremental implementation. Supporting community-based delivery of primary health services, quality childcare, learning opportunities, and early intervention services contributes to a generation of healthy young children who can become capable parents and community leaders in the future.

### **ECCD Outcomes Depend on the Overall Quality of Life in Communities**

Determinants of optimal development include many conditions of life in communities, such as social inclusion and support, housing, safety, nutrition, and the natural environment. Community development and improving child development outcomes can go hand and hand. Funding and support should support local initiatives that develop the capacity of a community to plan supports for families, mount programs for childcare and development, and deliver a range of services that contribute to child well-being according to internally-identified goals and strategies.

### **Locally Fitting Practices Are Not Best Practices That Would Fit Anywhere**

There are no best practices or one-size-fits-all childcare, education or health strategies that will work across diverse populations and locations. Community-fitting approaches to supporting early childhood development are likely to be more effective than top-down, expert-driven strategies or models purported to be best practices and imported from other contexts. Involving community members in forging useful pathways to achieving locally defined goals is part of the foundational work that leads to sustainable community-driven programs. Leaders in each setting need to consult with prospective user groups and take stock of resource constraints and opportunities when making major service system design decisions such as which services should be integrated and which should be separate but coordinated and the pace of introducing new programs to a service hub.

### **People Make Program Success**

- Programs are effective when they are tailored to the specific needs, goals, values and life circumstances of the people they are intended to serve.
- Programs are delivered by people. Targeted funds and efforts must support practitioners' ongoing learning and personal well-being (especially in rural and remote areas, where isolation creates extra burdens).
- Programs are sustainable when bridges are built and knowledge is shared between people across sectors, jurisdictions, communities, and regions.

### **Where There Are No Ready-Made Models**

Community-driven initiatives to strengthen the capacity of families and communities to meet the needs of young children require funding agencies, branches of government, regulatory bodies, community administrators and training institutions to open up the foundations of how community development and service delivery are conceived and supported. Communities that aim to develop coordinated, culturally informed and useful

programs of support to promote the well-being of young children and families must be given enough flexibility and long-term support to evolve and implement their own long-term vision. Communities that are ready and have the will to see a vision through to successful implementation will need funding to develop both the hard and soft infrastructure that is required to support the delivery of services to young children and their families.

From an accountability perspective, what is “good” integration? In many First Nations, elaboration of integrated and intersectoral hubs are a huge challenge and real accomplishment of community development. How can programs be evaluated when community development is perhaps the most meaningful outcome variable, and when every community starts at a different place, has different resources and challenges, and wants to pursue different priorities? There are no ready-made methodologies, indicators or tools for measuring these community-customized approaches, or for comparing community-driven programs. Researchers need to develop approaches to deriving “community-relevant” criteria and customized tools for monitoring program quality and measuring program outcomes, and to enable the effective communication of new knowledge so that promising practices can be identified and shared. Early signs of success—in terms of improved access, community utilization of services, cultural safety and congruence, efficiency, and capacity building—indicate that the concept of ECCD as hook and hub within a broad vision for community-centred services are promising practices from which we can learn.

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